

CHAPTER 3

THE PHENOMENON TRAUMATIC STRESS

3.1 Introduction

The point of departure of this study is that pastoral counsellors are not adequately trained with regard to posttraumatic stress that is experienced by spousal rape victims. Chapter 2 examined the phenomena of rape, acquaintance and spousal rape. This chapter focuses on the psychological trauma experienced by those who have been traumatised by rape and more specifically for the purposes of this study, spousal rape. In order to effectively counsel the victim of a traumatic event such as rape, pastoral counsellors should have an adequate understanding of psychological trauma.

The frequency of traumatic events resulting in traumatic reactions is high in South Africa. This is exacerbated by the fact that many individuals experience multiple traumatic events. According to Williams et al. (2007:852) the majority of South Africans experience not just one, but multiple traumatic events, 75 percent of South Africans have experienced some traumatic event in their lifetime, and 55.6 percent of South Africans have experienced more than one traumatic event. Hirschowitz, Worku and Orkin, (2000:28) refer to statistics released by the International Criminal Police Organisation ICPO-Interpol, 'International Crime Statistics' (1996), which confirm that South Africa has one of the highest incidences of rape in the world. Kernsmith (2008:58) points out that of those who report having been raped by a spouse, between 70 percent and 85 percent have experienced more than one rape, and 30 to 55 percent have been raped more than 20 times. These statistics highlight the hardship that South African women live with daily.

The field of psychology has contributed the most to the study of psychological trauma. This chapter therefore mainly makes use of the literature in this field.

Some pastoral counsellors do not approve of psychology and do not make use of the insights of this field (see Adams 1986, Burkley 1993, Almy 2000).

'Diagnosis' is a term that refers to the identification of the nature, causes and symptoms of a problem or difficulty. The word 'diagnosis' originates from the Greek word meaning 'discernment'. One of the most important qualities a pastoral counsellor should possess is that of discernment, or the ability to 'diagnose' the

situation. Benner (2003:80) puts it as follows: “Responsible pastoral counselling involves making a good diagnostic judgment about the nature of the problem”.

There are a number of psychological diagnostic tools that may be used to classify the symptoms of a client. While it is not the role of the pastoral counsellor to “label” a client, it is nevertheless useful for the pastoral counsellor to have an understanding of the various diagnostic classifications. The advantage of having a recognised set of diagnostic criteria is that the pastoral counsellor gains more insight into the things that he/she are told. This in turn leads to a more effective intervention and treatment approach. Backus (1985:31) makes a point that pastoral counsellors as well as health professionals need to determine how they can help the counselee and this would include discernment, assessment and diagnosis. Assessment and diagnosis result from observation and listening to reach a conclusion. All are necessary to select a plan of treatment.

3.2. Stress

3.2.1. Introduction

Stress is a rather complicated concept. Hans Selye (1936:32) an endocrinologist was the first person to define stress as “the non-specific response of the body to any demand for change”. A more contemporary description is that of Leaf (2007:40) who sees stress as “the body and mind’s response to any pressure that disrupts normal balance”. Stress has both physiological and psychological aspects. According to Davies (1995:817), stress may be understood in two different ways. Firstly, the term “stress” can describe specific *causes* or secondly, it can describe the end psychological and physiological result of internal and external pressures. All stress is initiated by a trigger (Leaf 2007:40). This trigger is known as a stressor and these stressors can be real or imagined, positive or negative.

‘Distress’ is the most commonly referred to type of stress and implies stress which has negative effects and implications. ‘Eustress’ is a positive form of stress which is usually related to desirable events in a person's life.

Hans Salye (1976) discusses the idea of a General Adaptation Syndrome as a system in terms of how the body responds to stress. His model states a stressor leads to a three-stage bodily response.

- The Alarm Reaction is the individual's immediate reaction to a stressor. The initial response to a stressor is for the body to lower its resistance and functionality. As the body recovers from this initial lowering of resistance, the individual present with what is known as a “fight or flight” response. This results in individuals being prepared for physical activity. Several body systems are activated “especially the nervous and endocrine systems” (Olpin & Hesson 2013:38). At this time the stress hormones adrenaline, noradrenaline and cortisol flow into the blood stream. (see Coon & Mitterer 2010:431)
- Should the stress continue, the body then enters the Resistance Phase and temporarily adjusts to the exposed stressors. The outcome is that the stress hormones stay activated in the blood stream. Coon & Mitterer (2010: 431) notes that it is during this stage that the first indications of psychosomatic disorders begin to appear. Even if the threat is no longer present, the perception of threat exists which causes the body not to return to its normal state of functioning and results in hyper-arousal (see Olpin & Hesson 2013:38). Further, due to this perception, “resistance to new stressors is impaired” (Hockenbury & Hockenbury 2010: 506).
- The Exhaustion Phase occurs when the stress has continued for a prolonged period of time. At this time the body’s resources are diminished and the stress hormones no longer are available to energise the body (see Coon & Mitterer 2010:38). The body's resilience to stress is then gradually eroded and it may collapse. The outcome of this period is frequently that the body's immune system and ability to resist disease deteriorates and may even result in death. . There are further signs of exhaustion displayed in the areas of emotion, behaviour and cognition.

3.2.2. Traumatic stress

The concept of trauma has previously been broadly discussed in this thesis. It is therefore necessary to clearly define this term. According to Weaver et al. (2004:9), the word trauma “is derived from the Greek word meaning ‘wound.’ Just as a physical trauma can cause suffering by wounding and disabling the body, a

psychological trauma can cause suffering by overwhelming the thoughts and feelings”.

Traumatic stress is linked to an event and the individual's reaction to that event. Trauma intervention is then expected not to focus only on the current reactions but also the victim's experience (factual happening, thoughts and emotions) during the traumatic event. The Diagnostic and Statistical Manual of Mental Disorders commonly known as DSM, contains the standard criteria by which mental disorders are classified. According to the DSM-III, (American Psychiatric Association, 1980, p. 238) 'trauma' is defined as a “recognizable stressor that would evoke significant symptoms of distress in almost anyone”. This definition of trauma was later modified in the DSM-III-R (American Psychiatric Association 1987:250) to mean an event that is “outside the range of usual human experience and that would be markedly distressing to almost anyone”. The definition was again later altered in the DSM-IV (American Psychiatric Association 1994:427–428) to be a 'traumatic event' in which the person faced an event that threatened serious injury or death; or a threat to the physical integrity of self or others, resulting in feelings of fear, helplessness, or horror.

According to Norris and Slone (2007:81-82), the DSM-IV definition was expanded to include events that would not have previously been considered, due to their frequency - such as the sudden and unexpected death of a loved one or a life-threatening illness. On the other hand, the second part of the definition was added in order to require that the event be experienced together with a sense of helplessness, terror, or horror. Breslau (2002:924) puts it as follows: “The DSM-IV revision - the broader range of qualifying traumatic events and the added criterion of a specific emotional response - deemphasizes the objective features of the stressors and highlights the clinical principle that people may perceive and respond differently to outwardly similar events”. According to Weaver et al. (2004:23), the impact of an experience always depends on its personal meaning to individuals and is linked to their pre-existing level of emotional sensitivity.

Posttraumatic stress has been a problem from humankind's inception. However, it has only fairly recently attracted the attention of scientists and doctors who attempted to understand the influence that traumatic events had on soldiers during and subsequent to various wars. Several terms were coined to describe their findings. During the American Civil War, combat related trauma was called 'Soldier's

heart'. In World War I doctors called it 'shell shock' and during World War II combat trauma was known as 'battle fatigue'. According to Goulston (2008:11), by the beginning of the Korean War, psychiatrists began to recognize aspects of what is called Posttraumatic Stress Disorder (but which was then referred to as 'gross stress reaction'). Psychological research relating to the Vietnam War resulted in the recognition of Posttraumatic Stress as a disorder which was then included in the Diagnostic and Statistical Manual of Mental Disorders in 1980.

However, it was not only during wartime that individuals were influenced by traumatic events. In the late nineteenth century, the term 'hysteria' was used to describe a medical condition that was thought to be particular to women. Nehiah (1968:871) points out that this phenomenon had also been associated with women in earlier civilizations. In fact, the ancient Greeks and Romans attributed this phenomenon to abnormal movements of the uterus. Jean-Martin Charcot (1825-1893) was a French neurologist who documented the symptoms of hysteria. As a neurologist, he was however more concerned with the physiological symptoms of the disorder than with his patients' emotions or feelings.

Sigmund Freud (1856-1939), a student of Charcot continued Charcot's work and discovered that Hysteria was also a condition caused by psychological trauma. Herman (1997:12) noticed that the studies conducted at these times resulted in an understanding that highly emotional reactions to traumatic events resulted in a changed state of consciousness, often inducing hysterical symptoms. As Freud furthered his studies, he discovered that hysterical symptoms could be alleviated through what he called 'psycho-analysis' or talking therapy. In 1896 Freud wrote in his report entitled 'Aetiology of Hysteria', that at "the bottom of every case of hysteria there are one or more occurrence of premature sexual experience" (Freud1989:103). This finding troubled Freud as he realized this implied that "respectable" bourgeois families (amongst others) were responsible for such acts against children and this fact he could not (or would not) accept. He therefore disassociated himself from the study of psychological trauma and from women. Herman (2007:15) observes that the study of psychological trauma came to a halt at this point.

It was not until the 1970s when the Women's Liberation Movement recognised that the most common posttraumatic disorders were not because of men being at war but rather of women living in civilian life. The purpose of this movement was however different to that of psychological therapy. It sought to affect social rather

than individual change. In the mid-1970s and due to the efforts of the women's movement, research into sexual assault was nevertheless brought into focus after it became apparent that some of the victims' symptoms resembled those previously identified in soldiers.

A number of models attempt to explain what is actually meant by traumatic stress. Figure 3.2 is a representation proposed by Dr. Merle Friedman (2008) and is used with her permission.

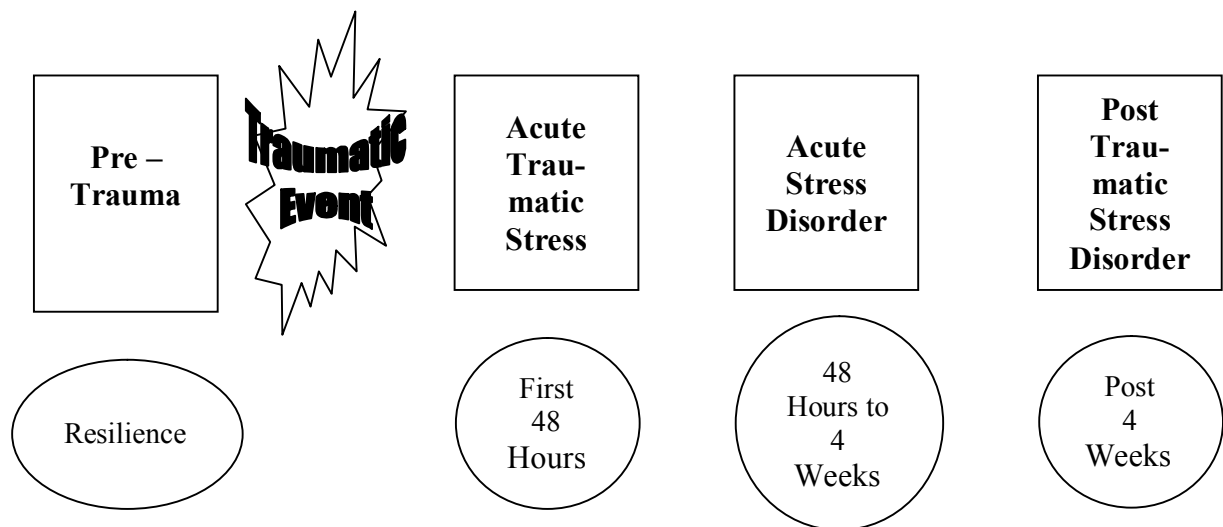


Figure 3.2

- **Pre-trauma**

Various pre-existing factors influence an individual's ability to cope with traumatic events. These include: age, gender, life circumstances, genes and brain structure, amongst others. A pertinent factor with regard to this study is that of gender.

According to Goulston (2008:31-32), women are twice as likely to develop Posttraumatic Stress Disorder when a trauma involves a physical assault - whether this is a sexual assault or another form of violent attack. Armfield (1994:740) adds that vulnerability to Posttraumatic Stress Disorder is “enhanced by pre-existing psychological disorders (especially if related to prior trauma), low self-esteem, family problems, and poor coping skills”.

- **During the traumatic event**

During a traumatic event, an individual experiences a number of various reactions and sensations. These include physical, emotional and mental reactions which are frequently accompanied by an overwhelming sense of fear and helplessness and an autonomic response to either freeze, flight or fight. In order to best understand why individuals undergo these changes at such times, it is useful to consider the responses of the brain and body during a traumatic event. Although in-depth neurological considerations are outside the scope of this study (cf. Neumeister et al 2007; Southwick et al 2007), a broad understanding is necessary due to the bearing it has on the ongoing responses experienced by traumatised exposed individuals.

Figure 3.3 (McKinley & O'Loughlin 2012:471) illustrates various areas of the brain involved during traumatic stress - in particular the hippocampus; hypothalamus and amygdala. These areas of the brain form part of the limbic system and influence emotions, learning, memory and self-preservation.

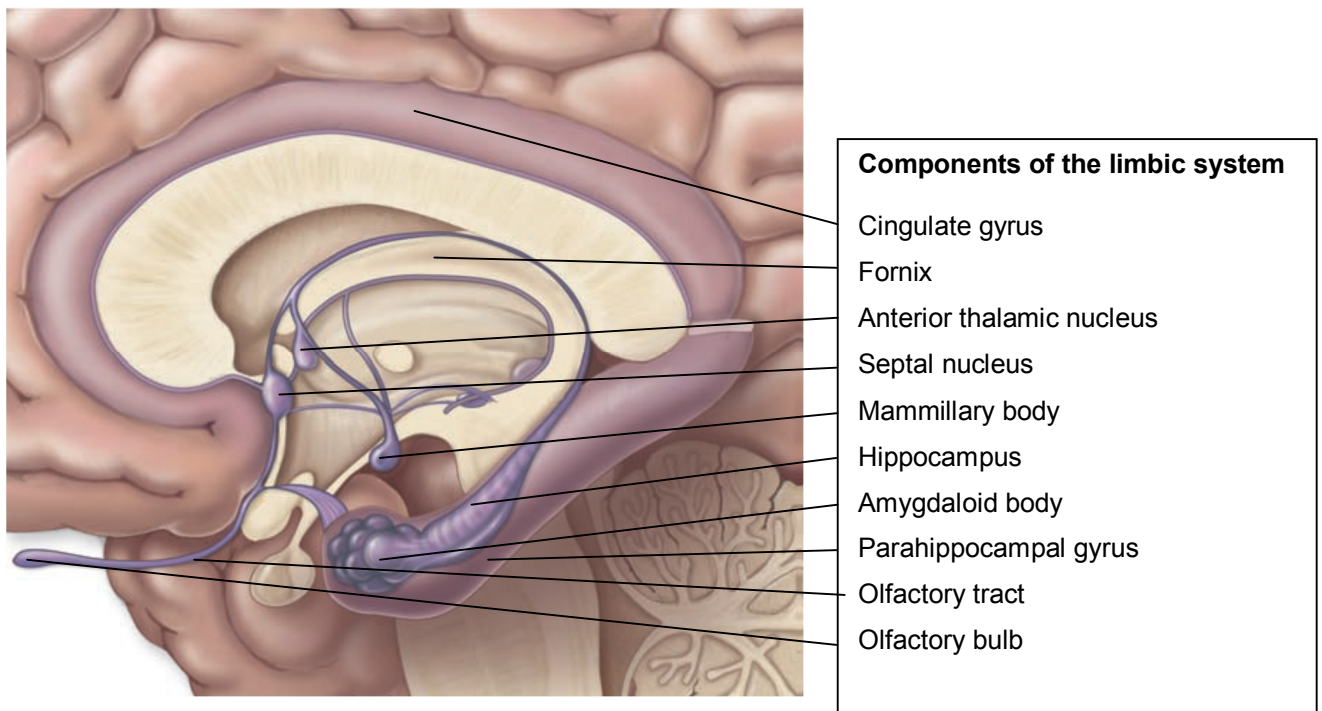


Figure 3.3

During a traumatic event, two systems of communication are simultaneously at work in the brain. This is illustrated in Figure 3.4. This illustration is a revised version of the flowchart of Conner (2002:234).

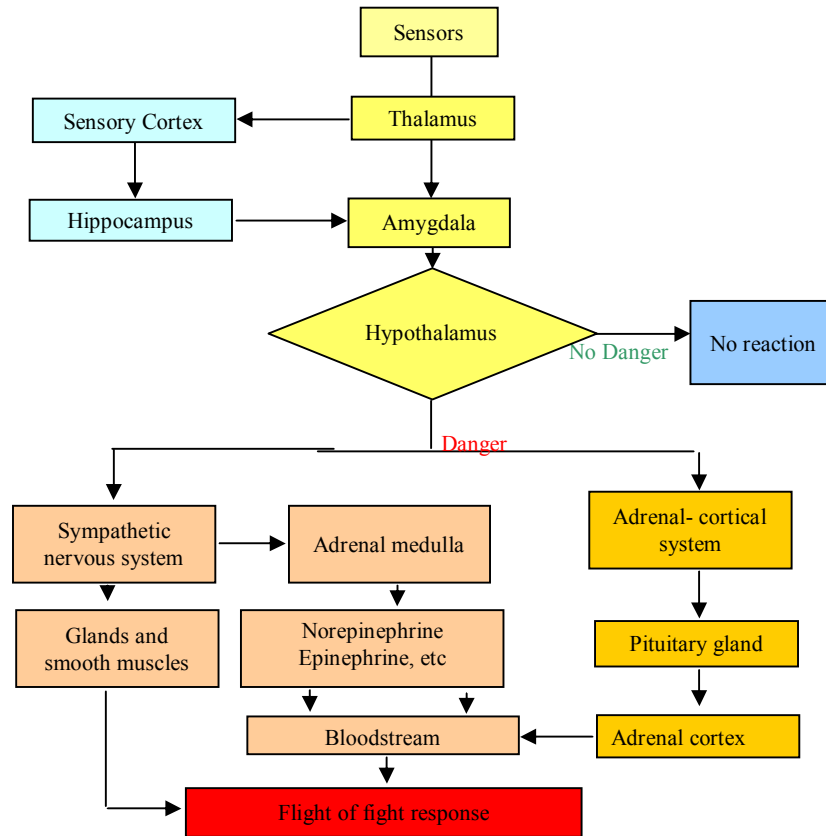


Figure 3.4

In the first system, incoming information from the senses is relayed to the thalamus. The thalamus then sends this information to the sensory cortex, where it is evaluated and assigned a meaning. Should the sensory cortex determine that there is more than one possible interpretation of the data, it passes the data along to the hippocampus, which ascertains whether or nor any experience could assist with an accurate interpretation. Should the hippocampus then determine that no threat exists; the information is sent to the amygdala, which signals the hypothalamus to shut off the fight-or-flight response.

The second system of information processing is much 'shorter-lived'. The information received by the thalamus is transferred directly to the amygdala, bypassing the hippocampus. The amygdala then receives the impulses and indicates

whether the hypothalamus should initiate a fight-or-flight response. The hypothalamus activates two systems: the sympathetic nervous system and the adrenal-cortical system. The sympathetic nervous system uses nerves to initiate reactions in the body, and the adrenal-cortical system uses the bloodstream for this purpose. The combined effects of these two systems result in what is commonly known as the fight-or-flight response. The rapid injection of epinephrine, norepinephrine and a number of other hormones cause changes in the body which result in the sensations, reactions and feelings experienced by a victim during a traumatic event. These responses are normal and expected, however they may become problematic should they persist. Talbott (2007:29, 30) explains it as follows: “Many stress physiologists believe that it is our degree of cortisol variability that indicates a healthy stress response: neither high cortisol nor low cortisol but a cortisol level that fluctuates normally in response to stress and relaxation”.

Factors which could further influence the victim’s response to traumatic events are: the nature of the trauma; the severity of the trauma; the duration of the trauma; the frequency of traumatic events; the victim’s proximity to the trauma and the victim's previous coping responses. These factors can be explained as follows:

- **Acute Traumatic Stress**

The first 48 hours subsequent to a traumatic event can result in a number of reactions which may persist for some time thereafter. This period is also known as the impact phase. This stage is confusing for the victim as their psychological, emotional, physiological and cognitive responses are powerful and seemingly contradictory.

Psychologically, a common response to a traumatic event is the experience of vivid flashbacks and frightening nightmares. In the early days subsequent to a trauma, the victim relives the event in every way. This results in the individual being flooded with chemicals and hormones and it is common for the victim to believe they are going mad due to this experience. At times, the victim may also experience disassociation. Cohen (2011:409) puts it as follows: “Dissociation’ is similar to a trance state, which is an altered state of consciousness in which awareness of the surrounding world is changed”. In this regard Saari (2005: 43) points out that dissociation is typical in extremely traumatic and long-lasting violent situations, including rape. While disassociation is a defence mechanism and a means of self-

protection, it hinders the processing of the traumatic event if it is extreme and persistent.

Emotionally, some trauma victims may feel numb, while others may experience varying intense emotions and yet others may vacillate between the two. The victim may weep uncontrollably with sadness or experience a sense of emptiness and despair. Feelings of anxiety, self-recrimination and guilt are typical. The most prominent emotions are however those of severe fear, helplessness and loss of control. According to Herman (1997:33), “psychological trauma is an affliction of the powerless”. Guilt and shame are also common feelings at this time. Saari (2005:46) explains that shame is an irrational emotion beyond common sense. The complication with guilt and shame is that they may affect the victim’s willingness to speak out about their experience.

Due to the bodily reaction during a traumatic event, the physical symptoms of aching muscles, tension headaches and such like is likely. While the mind may be over stimulated, the body is exhausted. Insomnia is a common response and may lead to further physical ailments. Physical care must be taken of the victim who has any pre-existing physical conditions, as the traumatic event may worsen these conditions. Saari (2005:47) refers to other typical somatic problems such as vomiting, nausea and cardiac symptoms.

Cognitively, the traumatic event may result in disorganised thinking. Retief (2004:32-33) points out that it is difficult to remember details or recall them in logical order after a traumatic event. As the victim's sense of security and trust is diminished, their increased sense of arousal and hyper-vigilance is common.

Spiritually, the victim's belief in the protection and even the very existence of God is challenged. Questions regarding the purpose and meaning of the event are asked of God. Herman (1997:51) notes that traumatic events can violate a victim’s faith.

Philosophically, the victim may question their world view, belief system and perceptions. According to Horowitz (2003:3), stressor events provide stimuli that drastically conflict with a person’s inner schemas. Bisbey & Bisbey (1999:24) point out that for the victim, prior thinking, security, confidence, experiences and expectations are considered to be invalid.

Relationally, the victim’s sense of trust and security and their emotional state is negatively influenced and it is not unusual for them to become irritable, quick

tempered and given to angry outbursts. This may result in damage to their support systems and relationships.

- **Acute Stress Disorder**

The diagnosis of Posttraumatic Stress Disorder (see below) as per the criteria in the DSM-IV can only be recognized at least 1 month after a trauma has occurred. The American Psychiatric Association (2004a:9), have expressed a need to introduce another disorder called Acute Stress Disorder (ASD) into the DSM-IV and note that “ASD was introduced into DSM in an effort to prospectively characterize the subpopulation of traumatically exposed persons with early symptoms and identify those at risk for the development of PTSD”.

The DSM-IV diagnostic criteria for ASD, as recorded by the American Psychiatric Association (1994:431–432) is found at Appendix 3.1 McNally et al. (2003:53) note that ASD and PTSD arise from the same set of traumatic stressors and are characterised by similar symptoms, however ASD differs in two significant ways. Firstly, the symptoms of ASD last between two days and 4 weeks and secondly, the ASD criteria emphasises dissociative reactions (cf. Scott & Stradling 2006:3-4; Brant 2004:188; Friedman et al. 2007:6; American Psychiatric Association 2004a:95). If symptoms of ASD are present for one month subsequent to trauma exposure, Posttraumatic Stress Disorder is then diagnosed (American Psychiatric Association 2004a:16).

The need for a diagnostic time frame has been highlighted. According to Foa et al (2009:130), ASD is a reasonable forecaster of Posttraumatic Stress Disorder as 75% of individuals with ASD subsequently develop chronic Posttraumatic Stress Disorder. Miller (2008:16) also recognises the value of the diagnosis of ASD as reinforcement of the importance of early treatment, particularly for crime victims, whose optimum clinical intervention begins at moment of contact with first responder.

Bryant (2004:192) criticises the use of the ASD diagnosis and states that “emphasizing dissociation as a critical factor in predicting subsequent PTSD leads to the neglect of other acute stress reactions that serve as risk factors”. Bryant (2004:194) goes on to note that a sensible approach would be to identify individuals at risk of developing Posttraumatic Stress Disorder by using a range of empirically supported indicators, rather than by relying on a diagnostic label.

- **Posttraumatic Stress Disorder (PTSD)**

According to Friedman (2003:4) PTSD is considered a significant public health problem, potentially affecting millions of Americans. The situation in South Africa is no different. According to Dr Eugene Allers (in Beeld newspaper June 04, 2008 – article by Antoinette Pienaar), psychiatrist and former-president of the South African Society of Psychiatry, up to six million South Africans suffer from posttraumatic stress disorder (PTSD). Vorster (2005) is concerned about the diagnosing of PTSD by South African psychiatrists. She puts it as follows: “PTSD as a *bona fide* diagnostic category has been eroded” (Vorster 2005:42) (emphasis is the author’s).

Pastoral counsellors are not qualified to diagnose any psychological disorders and are therefore required to refer their counselees to psychiatrists or forensic or clinical psychologists with expertise in the field of trauma. Nevertheless, the PTSD diagnosis is a useful tool for them in terms of being the first point of call for counselees and being able to refer these counselees to the appropriate professionals. This could eliminate other future compounding issues or co-morbid disorders for the counselees and thereby enable them to receive immediate and effective assistance. This is rather important in the light of Kinchin's (2007: 21) finding that rape victims are 50% more likely to suffer from posttraumatic stress disorder.

3.2.3. Posttraumatic Stress

Posttraumatic stress disorder was understood in the DSM-III as a syndrome caused by exposure to extreme stressors occurring outside the usual boundaries of everyday life. These events were likely to trigger noticeable distress in nearly all individuals. The initial studies concerning PTSD were undertaken with soldiers in war situations. As research developed, this definition was considered inadequate. The DSM-IV definition was therefore broadened to include the subjective perception of threat. To qualify as traumatised, an individual no longer should be a direct victim of trauma. One may also qualify because of being confronted with a situation that involves threat to the physical integrity of one’s self or others and experience the emotions of fear, horror, or helplessness. The DSM-IV has omitted the criteria that a traumatic stressor has to be “an event that is outside the range of usual human experience” (American Psychiatric Association, 1987:250) because it is unclear as to what constitutes a ‘usual’ human experience. The DSM-5, which is expected to be

released in 2013, proposes pertinent changes. By tightening up the A1 criterion, the new definition makes a better distinction between ‘traumatic’ and distressing events not exceeding the ‘traumatic threshold’. (cf. American Psychiatric Association, 2010). Another important addition in light of this study, is the recognition of “actual or threatened sexual violation” (American Psychiatric Association 2010) as grounds for posttraumatic stress disorder.

There are three main reaction clusters in PTSD. They are the following:

- **Intrusive symptoms**

The memory of the traumatic event continues to replay without any indication of subsiding. This replaying may take the form of nightmares, flashbacks and unsolicited thoughts. According to Friedman (2011:12) this intrusive thoughts are “sensory memories of short duration”. They have the quality of being in the immediate present and therefore lacks context. “Ruminative thoughts in depression”, on the other hand, are evaluative and longer lasting. Victims who experience flashbacks feel as if she/she is vividly reliving the traumatic event (see Okawa & Hauss 2007:41). Nightmares may result in the victim being too afraid to sleep which has a negative impact upon her/his health. Nightmares are one of the primary indicators that is recognised for PTSD (see Roberts & Roberts 2005:449).

- **Avoidance and numbing**

People with PTSD generally avoid doing anything that reminds them of the traumatic situation, including thinking about it. Not only do victim avoid thought and places but he/she may present with symptoms of social avoidance (Katz 2005:8). Some sufferers describe an inability to feel emotions such as love and happiness. Giarratano (2004:13) explains that with a combination of the numbing of positive emotions, feelings of detachment and avoidance of social situations, PTSD could have a devastating impact on the sufferer’s functional existence.

- **Hyperarousal**

The trauma victim may experience a range of physiological symptoms, such as an inability to sleep, an inability to concentrate and anger and irritability. The person may constantly feel alert and on guard, scanning the environment for signs of

danger. The person may additionally be very sensitive to noises and have an exaggerated startled response to unexpected or loud sounds. Hyperarousal is not limited to a victim's involuntary reaction to a stimulus but it is also associated to bodily sensations such as palpitations, dizziness and shortness of breath (see Taylor 2006:14).

Co-morbidity is a term that signifies the presence of one or more disorders in addition to a primary disorder (Heiby & Latner 2009:547). It describes the effects of the additional disorders and provides a more holistic view of a person's illness. This concept is particularly important when dealing with PTSD because it can cause the development of many other disorders.

Victims, who present with symptoms PTSD, often meet the criteria for at least one other psychiatric disorder (Friedman 2009:68). The most common of these co morbid disorders is Major Depressive Disorder, Anxiety Disorders and Substance-Related Disorders (see North et al 2010:119). These disorders can occur before, during, or after the onset of PTSD. Goldberg (1995: xiii) points out that "PTSD often occurs co-morbidly with other psychiatric disorders, making differentiation very difficult".

PTSD is officially classified as an anxiety disorder (Friedman et al 2010:4). Some are in disagreement and suggest that PTSD is better suited to be a dissociative disorder (see Widiger & Mullins-Sweatt 2007:12). It is important to understand these arguments as they affect treatment options:

- **Anxiety disorder**

According to Brett (1996:121), PTSD has a history of moving classifications. Posttraumatic reactions have been taken out of an adjustment and stress category and placed in the anxiety disorders by DSM III and its successors. This has resulted in researchers classifying PTSD as an anxiety disorder (see Foa & Rothbaum 1998:11; Clark & Beck 2010:552). There are however a number of objections to PTSD being considered an anxiety disorder.

- **Dissociative disorder**

Posttraumatic symptoms such as: flashbacks, out of body experiences, hallucinatory experiences and amnesia better suggest a dissociative rather than an anxiety disorder. The precursor to PTSD, or Acute Stress Disorder, is understood as being a

dissociative disorder. Brett (1996:123) explains that the “elaboration of the posttraumatic and dissociative symptom criteria for the new diagnosis follows naturally from this descriptive orientation”. The issue of PTSD being considered a dissociative disorder has resulted in significant research, amongst others, that of memory.

There are two main forms of memory, each dependent on the functioning of different parts of the brain: Explicit awareness (thought as memory) and the less accessible implicit memory. Implicit memory is also known as the sub-conscious. Siegel (1997:44) notes that it includes information that is acquired during skill learning, habit formation, simple classical conditioning and other information that is expressed through performance rather than recollection.

Traumatic experiences are ‘remembered differently’ from non-traumatic events. Bremner (2006:80) elaborates, “Individuals with posttraumatic stress disorder exhibit a broad range of problems with memory, including gaps in memory, problems with declarative memory, attentional biases to trauma-related information, and intrusive memories”.

Both the DSM-IV and ICD-10 diagnostic criteria recognize that trauma may consist of boundaries of retention and forgetting. (see American Psychiatric Association: 1994; World Health Organisation:2012) Trauma events can be remembered with intense clarity or not recollected at all. Van der Kolk (1995) suggests groups of functional turmoil. Firstly, traumatic amnesia may be present and may last for hours or weeks. Recall is generally triggered by exposure to sensory or emotional stimuli that match sensory or affective elements connected with the trauma. Secondly, global memory impairment may be present. This is normally associated with childhood trauma. The danger of this impairment is that victims of childhood trauma are vulnerable to suggestion and to the construction of accounts for their trauma-related emotions. Thirdly, trauma and dissociation may be present and cause the compartmentalization of an experience. The memory is stored as isolated segments and sensory awareness.

Bremner et al (1995) used magnetic resonance imaging (MRI) equipment to demonstrate that patients diagnosed with PTSD present with smaller volumes of the hippocampus, with a specific decrease in the right hippocampal volume. It is suggested that this results from PTSD and may result in deficits in short-term memory (see Bremner 2006:84).

3.3. Rape Trauma Syndrome

Men and woman are anatomically different but the difference also goes further. Gray (2008:38) notes that, due to advances in neuroscientific research, scientists have discovered significant differences between the male and female brains that explain the visible behavioural differences. These differences between men and women are also noticeable with regard to trauma reactions. Kimerling et al. (2007:210) note that while men are more prone to experience traumatic life events, women are more likely to develop PTSD. The chance of women developing PTSD is approximately twice that of males.

Handa and McGivern (2000:196-204) offer supporting evidence in terms of gender differences with regard to stress responses. This evidence includes differences in adrenal function, neuroendocrine function and behavioural responses to stress. Handa and McGivern (2000:203) conclude that “current research studying the interrelationships among sex, stress, and pathophysiology strongly implicates a role for gonadal hormones in predicting gender differences related to disease or psychopathology”.

These factors have huge implications with regard to treatment. Kimerling et al. (2007:222) believe that the issue of gender is a vital factor when treating PTSD and understanding its causes, progression and symptoms.

In 1972, Ann Burgess, a scholar in the field of nursing and sociologist Lynda Holmstrom observed a pattern of reactions in individuals who had been raped and labelled these as “rape trauma syndrome”. Leslie (2003:28) points out that this syndrome was the first comprehensive model formulated to understand the trauma of rape from the victim’s perspective. The term ‘Rape Trauma Syndrome’ is still used today. However, it is understood in different ways and has undergone some modification. This has led to confusion concerning the term. According to Van der Bijl (2006:116), Rape Trauma Syndrome has been used as a clinical term to describe many behavioural and interpersonal symptoms sometimes showing to varying degrees in rape victims. The organisation, Rape Crisis (2010), operating in Cape Town, has described Rape Trauma Syndrome as a ‘medical term’. Considering the syndrome to be a medical term may be considered misleading however, as it may imply that only physical reactions are present subsequent to a rape incident. The

original definition of Burgess and Holmstrom (1974:982) is more useful: “The acute phase and long-term reorganisation process that occurs as a result of forcible rape or attempted rape. This syndrome of behavioural, somatic and psychological reactions is an acute stress reaction to life threatening situations”.

While the term 'Rape Trauma Syndrome' was coined thirty five years ago, it is still in use today in South African and international courts to explain and identify the symptoms suffered by rape victims. Desiree Hansson (1993:18), clinical psychologist and Director of the Institute of Criminology at the University of Cape Town, has summarised her findings in a court case as follows: “my clinical opinion [is] that the complainant is currently suffering from Posttraumatic Stress Disorder, and more specifically from Rape Trauma Syndrome, probably accompanied by Selective Psychogenic Amnesia”. Hartman et al. (1993:511) explain that the reason for the ongoing use of the term 'Rape Trauma Syndrome' is that it provides “important descriptive information” as it is rape specific. The identification of Rape Trauma Syndrome is useful from a psychological perspective, as it considers the condition of the rape victim from a rape-related perspective. Rape Trauma Syndrome is not a recognised psychiatric/psychological disorder, as it has never been included in the DSM or ICD criteria.

Burgess and Holmstrom initially developed a two-phase model of the response to a rape experience, which consists of an acute phase and a re-organizational phase:

- **The acute phase**

The acute phase refers to the first few hours and weeks subsequent to the rape and is characterised by anxiety and fearfulness. “[T]he fear can become so salient and demanding that it overpowers the lives of victims” (Allison et al. 1993:153). Other general stress response symptoms are also present. The emotional responses displayed by the victim may be witnessed in either of the following two ways, depending on the personality of the victim and the nature of the rape. Firstly, the victim is openly emotional. She may appear agitated or hysterical and may suffer anxiety attacks. Secondly, the victim may have a ‘controlled’ response where strong feelings are masked behind a composed dementia.

In the first several weeks following a rape, acute somatic reactions such as physical trauma, sleep and appetite disturbance, gastro-intestinal irritability and

genito-urinary disturbance may occur (cf. Peterson, Prout & Schwarz 1991:52). Emotional responses at this stage may include humiliation, embarrassment, anger, a desire for revenge. According to Leslie (2003:164), the primary feelings following a rape are those of disbelief, numbness, disgust and betrayal. Because rape is a traumatic event, the victim is more likely to suffer the recognised trauma reactions of flashbacks, nightmares, hyper-vigilance and an elevated startle response in the acute phase.

- **The re-organisation phase**

The re-organisation phase occurs as the weeks pass and the rape victim is faced with the task of putting the broken pieces of her life back together. The victim begins to consciously re-organise the world in which she now lives. This is not an easy undertaking and the victim may experience phobias, disturbances in physical functioning, disturbances in sexual behaviour and changes in lifestyle (cf. Allison et al 1993:155). This phase is strongly influenced by the victim's personality, her support system, existing life problems and prior sexual victimization.

Trauma organisations and specialists have modified this model to include a third phase. The organisation Rape, Abuse & Incest National Network (2009) and others suggest a phase between the first and last phases known as the 'recoil' or 'pseudo adjustment'. "During this phase the individual resumes what appears to be his or her 'normal' life but inside is suffering from considerable turmoil" (Victim Advisory Council of Iowa Department of Corrections 2011:5).

Rape Trauma Syndrome is a useful concept for a number of other considerations. Firstly, the term rape trauma syndrome considers rape from the view of the victim. Secondly, rape trauma syndrome is a cluster of responses to the extreme stress experienced by the victim due to a sexual assault, both at the time immediately after the rape and the months and years that follow. Thirdly, rape trauma syndrome is not an illness or a personality disorder. Leslie (2003:38) puts it as follows: "It is a normal response to an abnormally traumatic event".

While most victims experience these symptoms, some may only experience a few of these symptoms while others may experience none at all. The probability of developing rape trauma syndrome is influenced by the victims' personal characteristics. Should the victim have well established coping skills and with high emotional and psychological stability, she is less likely to experience symptoms of

rape trauma syndrome. Nevertheless, a judgment as to whether a woman has been raped cannot be made on the consideration of the number of symptoms the woman displays.

The following statement of Hartman (1993:511) makes a direct connection between PTSD and Rape Trauma Syndrome: “For many rape victims, responses during a rape and after the rape correspond to the critical symptoms of posttraumatic stress disorder”. This statement is generally accepted by trauma specialists and is seldom debated. However, there are a number of varied and conflicting responses to question with regard to the relationship between PTSD and Rape Trauma Syndrome. According to the South African Department of Correctional Services (2008:12), Rape Trauma Syndrome can be viewed as a particular type of posttraumatic stress disorder that is evident after the occurrence of rape. This perception corresponds with that of Walker (1994: 30) who puts it as follows: “Rape trauma syndrome is now considered a subcategory of PTSD. Rape trauma syndrome has been explained as a part of PTSD”.

Others have argued “Posttraumatic stress disorder (PTSD) has replaced rape trauma syndrome as the descriptive label for the aftermath of rape” (Koss et.al. 1999:1184). In an interview Emsley, head of the Department of Psychiatry at the University of Stellenbosch, said that Rape Trauma Syndrome is not recognised as a psychiatric disorder in South Africa and it would be more accurate to characterise rape victims according to specific psychiatric conditions such as PTSD (Van der Bijl 2006:120; cf. Foa 1998:27). According to Walker (1994: 34), however, posttraumatic stress disorder is not an adequate diagnosis for all of the symptoms experienced by rape victims because it fails to recognise the variation of psychological responses over time. Walker (1994:34) is of the opinion that it would be more useful to use the descriptive diagnostic categories reflected in Rape Trauma Syndrome. Rape trauma syndrome differs from posttraumatic stress disorder in the following respects:

- Posttraumatic stress disorder is a psychiatric diagnostic category that has specific criteria for diagnosis, whereas rape trauma syndrome requires a general fit between the victim’s symptoms and the characteristics of the syndrome.

- Posttraumatic stress disorder can be caused by a number of events but rape trauma syndrome victims exhibit symptoms that are a common stress reaction to rape.
- Posttraumatic stress disorder as a diagnosis could result in the rape victim being viewed as a 'disorder to be corrected' and not as a unique individual in need of healing.

In conclusion, the diagnostic classification of posttraumatic stress disorder was specifically designed to be used as a diagnostic tool with soldiers in mind. It may therefore be inadequate in terms of fully comprehending the experiences of rape victims and the aftermath of rape. Nevertheless, the precepts of posttraumatic stress disorder and more specifically, rape-related posttraumatic stress disorder (see below) are important for pastoral counsellors to understand. Much that has been written on rape was done from a posttraumatic stress disorder perspective. For the pastoral counsellor it is important to be familiar with the terminology and aspects of posttraumatic stress disorder since because other professionals with whom the pastoral counsellor co-operates in a multi-disciplinary team, will probably work within this framework. In addition, these insights from psychology can enable pastoral counsellors to recognise and deal effectively with situations of rape.

The diagnosis of posttraumatic stress disorder does not fully account for the varied symptoms that women could experience subsequent to a rape. Herman (2007:32) observes that only after concept of posttraumatic stress disorder had been legitimated by the efforts of combat veterans, "did it become clear that the psychological syndrome seen in survivors of rape, domestic battery and incest was essentially the same as the syndrome seen in survivors of war". The diagnosis of PTSD does not fully accommodate rape victims in terms of its criteria. Organisations such as the National Center for Victims of Crime in Washington make use of a term called Rape-Related Posttraumatic Stress Disorder. There following are the four major symptoms of Rape-related Posttraumatic Stress Disorder (Jasper 2007:31):

- **Re-experiencing the traumatic event**

Rape victims may experience uncontrollable intrusive thoughts regarding their rape. Vivid memories and triggers (any stimuli or situations which remind them of the rape) during the day may cause them to become preoccupied with their rape and to be unable to shift their focus from the incident. Rape victims have realistic nightmares and flashbacks concerning the rape, where they re-experience the rape as if it were happening again.

- **Social withdrawal**

Rape victims frequently avoid contact with significant others, friends, acquaintances and social groups subsequent to their rape. Brown (2007:196) refers to social withdrawal “as psychic numbing, denial and a feeling of being emotionally dead”. Victims are emotionally blunted or numb and this manifests in a diminished interest in living and even a lack of interest in their children and their jobs.

- **Avoidance behaviours and actions**

Rape victims may experience a tendency to avoid any thoughts, feelings or triggers which would remind them of their rape. For example, a victim may refuse to drive near the spot where her rape occurred.

- **Physiological arousal characteristics**

Rape victims may present with exaggerated startle response, hyper-alertness and hyper-vigilance. The victims may be in such a state of arousal that they respond to every sound and sight in their vicinity. Sleep disorders are common and result in poor sleep habits, such as trouble falling or staying asleep. Victims may also exhibit changes in their personalities. This has negative consequences for their interpersonal relationships. Outbursts of irritability, hostility, rage and anger, etc. result in victims being further isolated.

Some survivors with rape-related posttraumatic stress disorder are unable to judge time frames clearly and may arrive late or early for appointments - or even fail to arrive at all. Another possible side effect is a kind of 'tunnel vision', where victims are unable to distinguish between small issues and large crises. Their focus is on the 'now' and the 'self'. Many victims with rape-related posttraumatic stress disorder go on to develop major clinical

depression. Foa & Rothbaum (2001: 28) indicate that of the victims of more than one rape, 20% were currently suffering from depression and the remaining 80% would undoubtedly be diagnosed with depression at some stage in their lives. There is also a high probability of rape victims with posttraumatic stress disorder attempting suicide. According to Basile (2005:110), thoughts of and attempts at suicide are psychological consequences showing a larger increase in likelihood for rape survivors than for women who have never been victims.

According to Jaycox et al (2002: 892) most rape victims display posttraumatic stress disorder symptoms immediately after a rape and for some, these symptoms persist for years with devastating consequences. Drug and alcohol consumption is likely to increase as rape victims attempt to regain control and cope with the symptoms. The danger is that rape victims could develop “an alcohol use disorder” (Feeny and Foa 2000:437).

3.4. Summary

This chapter traced the broad outline of trauma, traumatic reactions and trauma disorders. This broad understanding was applied specifically to the trauma as experienced by rape victims and various rape reactions, symptoms and related issues were explored. The impact of the traumatic event or rape on the spiritual well-being of the rape victim will be addressed in Chapter 4

CHAPTER 4

QUESTIONNAIRES AND INTERVIEWS

4.1. Introduction

The subject of posttraumatic stress because of spousal rape involves a number of different disciplines, therefore:

- Questionnaires were sent via email to 300 churches, individual pastoral counsellors, relevant para-church organisations and associations;
- Questionnaires were sent via email to members of the psychological fraternal. (These questionnaires are found in Appendix 5.1 and 5.2 respectively and the results are recorded below);
- Interviews were conducted with three women who have been victims of spousal rape. (The interview questions are found in Appendix 5.3 and the results are recorded below).

4.2 Data analysis: Pastoral counsellors

This study focuses on qualified and recognised pastoral counsellors - both within and outside the domain of the local church. The Senior Pastor of any local church is not considered a pastoral counsellor, unless pastoral counselling constitutes part of his/her job description.

Approximately 300 questionnaires were sent to various churches of different denominations, relevant Christian organisations and associations and individual pastoral counsellors throughout South Africa. The number of replies received totalled 71. These results are documented in Appendix 5.4 and presented in Table 4.1

		Female	Male	Total
No. of Participants		33	38	71
Qualifications	Matric (Grade 12) Certificate	0%	0%	0%
	Other Tertiary Certificate	1.6%	0%	1.6%
	Diploma	1.6%	8%	9.6%
	Bachelors Degree	8%	11.1%	19.3%
	Honours Degree	8%	8%	16.1%
	Licentiate	0%	1.6%	1.6%

	Masters Degree	14.4%	17.6%	32.3%
	Doctoral Degree	6.4%	12.8%	19.4%
Church Stream	Pentecostal	7.7%	7.7%	15.4%
	Charismatic	10.8%	6.2%	16.9%
	Mainstream (Anglican etc.)	6.2%	12.3%	18.5%
	Evangelical	6.2%	10.8%	16.9%
	Reformed	9.2%	23.1%	32.3%
View of Scripture	Inspired Word of God	36.1%	56%	92.1%
	Writings of Men	4.8%	3.2%	8%
View of Gender Roles	Patriarchal	1.7%	4.3%	5%
	Egalitarian	10.2%	13.6%	23.7%
	Complementarian	18.6%	32.2%	46.5%
	Evangelical Feminist	6.8%	6.8%	13.6%
	Liberal Feminist	8.5%	1.7%	10.2%
Nature of Cases Counselled	General Trauma	88.9%	81.0%	85%
	General Rape	77.8%	38.1%	58%
	Spousal Rape			28.1%
Perception of Challenge	Spousal Rape is a challenge for pastoral counselling			82.7%
Referral Base	Psychologists who practice from a Christian perspective			22.7%
	Psychologists who do not practice from any religious perspectives			8.2%
	Therapists who practice from a Christian perspective			24.7%
	Therapists who do not practice from any religious perspectives			4.1%
	Other Organizations:			19.9%
	No-one			1%
	No Referral Requested			30%
No. of Counselling Sessions per Spousal Rape Case	1 Session			0%
	2-4 Sessions			56.3%
	5-10 Sessions			30%
	11+ Sessions			13%

Table 4.1

A greater percentage of respondents (53.5%) are male pastoral counsellors, while 46.5% of respondents are female. This fact dispelled my preconception that there is a 'male-based pastoral counselling fraternity' in South Africa.

An average of 51.7% of respondents have graduated with either a Masters or Doctoral degree, however the male respondents are more highly qualified (30.4%) than the females (20.8%).

Both male and female respondents acknowledge a high regard for Scripture - with 92.1% of respondents believe that in the divine inspiration of the Bible. This result is consistent with the fact that 48.2% of the respondents aligned themselves with Evangelical and Reformed theological streams, thereby indicating that the majority of them hold to a conservative Christian worldview. This fact is further borne out by the similarity in perceptions of gender roles by both male and female respondents: 20.3% of female and 36.5% of male respondents also hold to a Patriarchal/Complementarian view. It must be noted however that more male respondents (20.2%) hold to an Egalitarian/Evangelical Feminist view, as compared to 17% of their female counterparts.

The majority of the respondents (female 88.9% and male 81%) counsel trauma victims. However, 77.8% of female respondents actively counsel rape victims, as opposed to 38.1% of male respondents. This seems to indicate that women who have been raped prefer the counsel of females to males. Nevertheless, the percentage of male pastoral counsellors counselling rape is higher than might be expected. The reason for this was not explored in the questionnaire. This could be as a result of the following two factors: firstly, assistance for the rape victims may be limited to the availability and accessibility of male counsellors only or secondly, some rape victims may prefer to be counselled by a male.

When the rape involves a spouse, the total number of rape cases counselled by respondents drops from 58% for general rape counselling, to 28.1% for spousal rape. This percentage is lower than the number of pastoral counsellors (30%) who have never been requested to counsel spousal rape. The reason for the lower number of spousal rape cases being counselled compared to other rape cases was not explored in the questionnaire but some possible explanations are the following:

- Firstly, there may be fewer incidents of spousal rape as compared to other incidents and forms of rape.
- Secondly, victims of spousal rape may be more unwilling to acknowledge that they were actually raped by their spouse.
- Thirdly, victims of spousal rape may not consider pastoral counsellors to be an appropriate resource to deal with the spousal rape incident.
- Fourthly, victims of spousal rape may be unaware that they have actually been raped due to the churches' teaching and a lack of understanding of the law.
- Fifthly, victims of spousal rape may be embarrassed and/or humiliated to acknowledge their rape to pastoral counsellors due to their perceptions of the church, Christians and the clergy.

Whilst it is noted that pastoral counsellors have a low incidence of spousal rape victim counselling, 82.7 % of respondents acknowledge that the issue of spousal rape is in fact a challenge for the local church. The reason for this belief may be due to the individual perceptions and experiences, or due to the fact that they actually perceive evidence of this trend being reflected within the church. Whatever the reason, the respondents concede that they are not adequately dealing with a problem that they themselves recognise as a challenge within the church. This study therefore specifically focuses on spousal rape within the church. The statistics also point to the need for preventative measures to be implemented by pastoral counsellors in churches in order to address this matter of spousal rape within the local church.

The results of the questionnaire demonstrate that 56.3% of counselling with spousal rape victims takes place within a period of 4 sessions or less. This means that the spousal rape victims are either inadequately counselled or that the respondents/pastoral counsellors are referring spousal rape victims to other counsellors. The latter seems more plausible as the results indicate a high volume of referrals. Most referrals are made to psychologists (22.7%) and therapists (24.7%) who openly describe themselves as Christians. Other organisations such as POWA are also widely used (19.9%).

This study proposes that pastoral counsellors ought to be capable of adequately counselling and caring for the needs of spousal rape victims. The results

of the questionnaire indicate that pastoral counsellors are generally well educated and that the majority of respondents counselling spousal rape are women. There is therefore no reason for spousal rape victims to be referred elsewhere at the rate they are. Pastoral counsellors should network and engage with other service providers. They should receive adequate counselling training and supervision, and should initiate strategies that are in the best interest of spousal rape victims.

4.3. Data analysis: Health practitioners

The term 'health practitioners' refers to counsellors, social workers and psychologists who work within a specialised environment. Approximately 100 questionnaires were electronically sent to rape centres, relevant organisations and individual psychologists and counsellors and only 22 were returned (see Appendix 5.2). The motivation for sending questionnaires to these individuals is was to determine their views and treatment approaches with regard to rape victims. This was undertaken in order to obtain an understanding of whether or not there was a difference in approach to rape between the genders. I was also interested in the health practitioners' perception of males counselling rape victims in addition to the role of the pastoral counsellor with regard to women that have been raped. Table 4.2 indicates the percentage of male and female respondents, in addition to an average.

		Female	Male	Total/Average
Participants		18	4	22
Qualifications	Matric	0%	0%	0%
	Certificate	0%	0%	0%
	Diploma	9%	0%	9%
	Bachelors Degree	9%	0%	9%
	Honours Degree	13.6%	0%	13.6%
	Licentiate	0%	0%	0%
	Masters Degree	31.8%	18.2%	50%
	Doctoral Degree	18.2%	0%	18.2%
Cases Counsellled	Counselling of General Trauma	86%	9%	96%
	Counselling of Rape	86%	9%	96%
Referrals	Psychologists	27.3%	0%	27.3%
	Therapists/ Social Workers	27.3%	0%	27.3%
	Church/Pastors/Priests	0%	18.2%	18.2%

	Other organizations	18.2%	0%	18.2%
	No Referral	0%	0%	0%
	Referral not Requested	9.1%	0%	9.1%
No. of Sessions	1 Session	4.5%	0%	4.5%
	2-4 Sessions	27.2%	9.1%	36.3%
	5-10 Sessions	31.8%	0%	31.8%
	11+ Sessions	27.2%	0%	27.2%
	Therapy Models	CBT	12.9%	6.4%
	EMDR	9.6%	0%	9.6%
	Exposure Therapy	0%	3.2%	3.2%
	Biofeedback	0%	0%	0%
	Art/Music/Drama	3.2%	3.2%	6.4%
	Narrative	35.5%	3.2%	38.7%
	TIR	6.4%	3.2%	9.6%
	Other	12.9%	0%	12.9%
		True	False	Uncertain
	No men should counsel rape victims	9.5%	80.1%	9.5%
	Rape impacts spiritual beliefs	80.1%	0%	19.1%
	Pastoral counselling necessary for rape victims	71.4%	0%	28.6%

Table 4.2

The return of the questionnaire from rape crisis organizations was poor and in one case criticism was made of the use of the term “victim” when referring to women who have experienced a rape. (For the motivation of the usage of this term see Section 2.3 Definitions of victim and survivor.)

The returned questionnaires revealed that of the 22 participants, only 4 were male. A possible reason for this finding is that female mental health practitioners are more likely to treat rape victims than their male counterparts. It is notable that 80.15% of these respondents believe it is not inappropriate for men to counsel rape victims. However, this does not seem to occur much in practice.

The high percentage of general trauma (96%) and rape (96%) cases counselled by both sexes is not out of the ordinary, since questionnaires were sent to mental health practitioners and organisations that are known to work with rape victims.

The respondents are highly qualified and 68.2% have attained either a Masters or Doctoral degree. This is probably due to the fact that most professional registering bodies require specific minimum academic qualifications.

Only three respondents indicated that they referred their rape cases. These referrals were primarily to other psychologists or therapists. Only two of the respondents referred victims to pastoral counsellors. This figure is significant, as 80.1% of the respondents indicated that rapes affected rape victims' spiritual beliefs. Interestingly, 71.4% of the respondents believe that pastoral counsellors have a role to play in the well-being of rape victims. Paradoxically, a low percentage of referrals are actually made to pastoral counsellors.

In terms of therapeutic modalities utilised by the respondents, Cognitive Behavioural Therapy (CBT) is the second most popular therapeutic model used when counselling rape victims (19.5%). In Chapter 3 of this study CBT is discussed as an effective therapeutic method for treating posttraumatic stress disorder. Chapter 4 points out that victims of rape are the most likely to experience posttraumatic stress disorder, I therefore expected the usage of CBT by the respondents to be higher.

A further therapeutic model recognised to be effective in the treatment of posttraumatic stress disorder is Eye Movement Desensitization and Reprocessing (EMDR). However, the number of respondents who apply this method is low (9.6%). This may be due to factors such as the cost of attending an EMDR course, the fact that respondents have not been exposed to the EMDR model, the fact that the model is not incorporated into university syllabuses, or simply that respondents do not choose to use this method. The most popular therapy model used by the respondents is the narrative model (38.7%). Narrative therapy covers a wide range of therapeutic methods. The questionnaire was not designed to explore the various forms of narrative used by the respondents since such detail is not required for the purposes of this study.

Approximately 40% of the respondents counsel rape victims for 2 to 4 sessions. This could be an indication that the work undertaken by the respondents takes the form of intervention programs. According to Hamblen (2010:3), "CBT treatment for PTSD often lasts for 3 to 6 months. Other types of treatment for PTSD can last longer. If you have other mental health problems as well as PTSD, treatment may last for 1 to 2 years or longer". It is difficult to understand how a rape victim will

recover from only 2-4 sessions of treatment. These figures suggest that rape victims are not assisted adequately, because of inadequate therapeutic duration and possibly ineffective treatment methodologies being utilised.

Highly qualified pastoral counsellors frequently refer victims of spousal rape to mental health practitioners who may not be adequately treating spousal rape victims because the spiritual aspect is not addressed. For many people their religion is central to their lives. Not including their spirituality in the recovery process affects the victim's recovery.

4.4. Interviews

Interviews were conducted with three spousal rape victims. The names of those involved have been changed for the purpose of confidentiality.

4.4.1. Interview 1

I conducted an interview with Cheryl, a woman married for 19 years who has three children. Cheryl had never been married before and is currently residing with her abusive husband. She was attracted to John because of his physical size, as she felt that he would be able to protect her. Cheryl also enjoyed the fact that John relied on her for emotional and practical support and care. Cheryl and John's courting process had a relatively short duration. Within three months of meeting, they began cohabiting and were married seven months later. In the early days of the marriage their relationship was fulfilling. Cheryl felt that she could care for John and was physically protected. Cheryl's parents' relationship lacked communication; however her father was never psychically abusive towards her mother. Within a few months, Cheryl began to perceive John as being verbally abusive and controlling. John limited Cheryl's movement out of the home and gradually isolated her from family and friends. Cheryl's only interaction with others was with John's friends and family. John would expect Cheryl to be ready to meet with his family and friends at a moment's notice.

John initiated their first sexual encounter prior to their marriage. Cheryl was afraid to say no and "consented" as she was afraid that he would leave her if she displeased him. Cheryl was a virgin at the time and had planned to be a virgin bride. Cheryl describes their sexual relationship during their cohabitation period as "fine". However, she notes that after their marriage John expected her to perform sexual acts

which made her uncomfortable and to which she felt unable to say no. Cheryl was under the impression that it was her wifely duty to be compliant. She also felt that sexual interaction was the only means of attracting John's attention. Although John usually initiated sexual intercourse, Cheryl sometimes initiated this in order "win his love". Incidents of spousal rape occurred a number of times throughout the marriage. At times these incidents included "rough sex" (including Cheryl being "strangled"). Initially Cheryl expressed shock and even cried during intercourse. However, as the incidents of rape continued Cheryl notes that she "was not there" and dissociated. This situation was further complicated by Cheryl's childhood sexual abuse.

Cheryl indicated that she never thought of the forced/coerced sex as rape until recently. She now believes it to be rape as there was "no willing verbal consent" from her side. Cheryl never filed a protection order against John.

Cheryl has not told anyone of her sexually abusive marriage and does not know of anyone else who has had a similar relationship. Cheryl's reason for not telling anyone is that she "feels like dirt" and is unable to bring herself to blame John or believe that he is capable of such behaviour. Furthermore, Cheryl experiences a sense of helplessness and believes that no one can change her situation.

Cheryl is unable to identify with God the Father as being protective and caring. She is however able to closely align herself with Jesus and His suffering. Cheryl acknowledges that her Christian faith is a source of help on the one hand and hindrance on the other. She believes that she is "not a mistake" and that being made in the image of God, gives her life meaning. Further, she believes that God has a plan for her life that will bring God glory. While she believes she is accepted and cleansed by God, Cheryl still considers herself to have no dignity.

Cheryl feels isolated from other believers "because they won't believe her". She has never approached a professional counsellor because of her sexual abuse, nor has she received any pastoral counselling in this regard. Cheryl's reason for this is that she feels unable to trust pastors. She is afraid that they will exacerbate her guilt and instruct her to submit to her husband (and thereby blame her to some extent) even if they actually believe her in the first place.

Cheryl's results in terms of the *Impact of Event Scale – Revised* (Wiess & Marmar 1996) (Table 4.3) reveal that she is hyper-avoidant of the spousal rape she has endured and may endure again in the future.

IMPACT OF EVENT SCALE – REVISED

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?

Item Response Anchors are:

0 = Not at all; 1 = A little bit; 2 = Moderately; 3 = Quite a bit; 4 = Extremely.

Thus, scores can range from 0 through 4.

1. Any reminder brought back feelings about it. **3**
2. I had trouble staying asleep. **4**
3. Other things kept making me think about it. **2**
4. I felt irritable and angry. **0**
5. I avoided letting myself get upset when I thought about it or was reminded of it. **4**
6. I thought about it when I didn't mean to. **0**
7. I felt as if it hadn't happened or wasn't real. **4**
8. I stayed away from reminders of it. **0**
9. Pictures about it popped into my mind. **0**
10. I was jumpy and easily startled. **0**
11. I tried not to think about it. **4**
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them. **4**
13. My feelings about it were kind of numb. **3**
14. I found myself acting or feeling like I was back at that time. **I don't visit**
15. I had trouble falling asleep. **3**
16. I had waves of strong feelings about it. **0**
17. I tried to remove it from my memory. **4**
18. I had trouble concentrating. **I suffer from depression**
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart. Cause me to punish myself

20. I had dreams about it. **0**
21. I felt watchful and on-guard. **0**
22. I tried not to talk about it. **4**
- Total IES-R score: 39

The **Intrusion** subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20.

9

The **Avoidance** subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17,

22. **27**

The **Hyperarousal** subscale is the **MEAN** item response of items 4, 10, 15, 18, 19,

21. **3**

Table 4.3

4.4.2. Interview 2

An interview was conducted with Mary, a woman who was in her third marriage. The incidents of spousal rape took place with her first husband, Peter. During Mary's first marriage, there were multiple incidents of rape. Mary in fact described incidents of rape prior to their wedding. Mary believes that Peter continued with their wedding plans due to a sense of obligation because of his sexual abuse of her. The main aspect that attracted Mary to Peter was the fact that he "protected" her from her abusive mother. Her dream was to marry and "live happily ever after". This marriage lasted almost six years and no children were borne from the union. Mary explained that her marriage to Peter had a number of similarities to her parents' marriage, which was characterised by verbal and physical abuse. During Mary's marriage to Peter, she experienced sex as mechanical - something she performed out of duty and obligation. This sexual relationship was coercive in nature, as at all costs, Mary wanted to avoid the verbal abuse she would endure if she did not "co-operate". Peter forced Mary to watch pornographic material and took nude pictures of her. Mary notes that Peter was not physically abusive towards her, however she also paradoxically states that there were times when he "slammed me against the wall".

During their marriage, Mary never believed that Peter had raped her. Rather, she believed that, as a woman, it was not her place to object to the desires of her husband. This resulted in Mary failing to file any protection orders against Peter. Mary did acknowledge however, that she was fearful and wished she could run away. At that point in her life, Mary described herself as religious, but not a Christian. She felt that God had let her down and even today, after being “reborn”, states that she is disappointed with God. Mary has no further contact with Peter who now lives in America.

Mary indicates that she has never encountered anyone who has experienced a similar situation to hers. She never spoke to anyone regarding her rape because “I didn’t think I had that right”. Mary therefore received no counselling during the time of her sexual abuse. Mary kept her suffering totally to herself. During her third marriage, Mary experienced marital difficulties and sought the counsel of five different pastors (two male and three female). Although she did not mention her rape by Peter first, she did mention the incidents of being forced to watch porn. This was the first time that Mary was told that she had been sexually abused. Mary has a high view of the role of the church with regard to marital abuse. She believes that men who are outside of the church escape the consequences of being reprimanded by pastors for wrongdoing. However, she also indicates that her experiences with pastoral counsellors have been less than useful. She feels that not all pastoral counsellors are sensitive and that they attempt to find quick solutions. She believes that pastoral counsellors require appropriate training in order to be better equipped to deal with abused women.

As a Christian, Mary realises that she is forgiven, however she notes that she also should forgive herself for her perceived wrongdoing. She explains that she believes she has done wrong by “participating in the abuse and not fighting back”.

Contrary to popular belief, Mary believes that patriarchy does not contribute to rape if males should conduct themselves according to biblical principles. Mary notes that she accepts a patriarchal marriage because she regards it as biblical. According to Mary, her perception of marriage, men and herself has been negatively affected by her experiences.

The results of Mary’s *Impact of Event Scale-Revised* (Wiess & Marmar 1996) are found in Table 4.4. These results indicate that at present she experiences avoidance, intrusion and hyperarousal reactions due to her trauma.

Mary is at present undergoing professional counselling.

IMPACT OF EVENT SCALE – REVISED

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?

Item Response Anchors are:

0 = Not at all; 1 = A little bit; 2 = Moderately; 3 = Quite a bit; 4 = Extremely.

Thus, scores can range from 0 through 4.

1. Any reminder brought back feelings about it. **4**
2. I had trouble staying asleep. **2**
3. Other things kept making me think about it. **4**
4. I felt irritable and angry. **4**
5. I avoided letting myself get upset when I thought about it or was reminded of it. **1**
6. I thought about it when I didn't mean to. **0 try to block out**
7. I felt as if it hadn't happened or wasn't real. **4**
8. I stayed away from reminders of it. **0**
9. Pictures about it popped into my mind. **0**
10. I was jumpy and easily startled. **4**
11. I tried not to think about it. **3**
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them. **4**
13. My feelings about it were kind of numb. **3**
14. I found myself acting or feeling like I was back at that time. **?**
15. I had trouble falling asleep. **2 on medication**
16. I had waves of strong feelings about it. **4**
17. I tried to remove it from my memory. **3**
18. I had trouble concentrating. **1**

19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart. Cause me to punish myself. **1**

20. I had dreams about it. **1**

21. I felt watchful and on-guard. **4**

22. I tried not to talk about it.

Total IES-R score: 49

The **Intrusion** subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20.

15

The **Avoidance** subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17,

22. **18**

The **Hyperarousal** subscale is the **MEAN** item response of items 4, 10, 15, 18, 19,

21. **16**

Table 4.4

4.4.3. Interview 3

This interview took place with Jane. Jane is currently unmarried but was married for eleven years during which time that the rapes took place. When Jane first met John, he presented as a charming and friendly person. The couple dated for just over a year prior to their marriage. Jane believed her future marriage would be “perfect”. She pictured having children and John fulfilling the role of leader in the home - someone on whom she could depend for security and protection.

Jane’s parents did not enjoy an idyllic marriage; however she does not consider their relationship to have been dysfunctional. Soon after her marriage however, Jane recognised that John was frequently verbally and sexually aggressive. Their sexual relationship also became unpleasant. Jane did not enjoy her first sexual encounter on her honeymoon night and notes that John was sexually demanding in terms of sexual frequency and had a high sex drive. No compromise could be reached in terms of sexual frequency. Instead, John grew more and more aggressive. This resulted in John forcing sexual intercourse upon Jane on numerous occasions. Jane notes that this caused her to feel like a prostitute especially as John treated her as if nothing had taken place prior to such incidents. Jane understood that John was raping her;

however she never laid any criminal charges or filed a protection order against him. Jane eventually divorced John and has no further contact with him.

Jane is unaware of any other spouse who has shared similar experiences to her. Only after a number of years did Jane feel free to mention the incidents to a lay counsellor and finally, to her family and close friends. Jane initially consulted her counsellor because the incidents “haunted” her and she needed to make peace with them. However, her counsellor was “flabbergasted” and did not know what to say or do. Her friends also never knew how to respond to her rape and the incidents have never been spoken about again. Jane subsequently consulted a professional therapist who was understanding and assisted her to work through her trauma. At no time did Jane seek assistance from a hospital or church.

Jane’s marriage had a negative impact on her Christian faith. She did not know how to reconcile what was happening to her with her faith and found herself withdrawing from God due to the guilt and shame she felt. Today she notes that she still holds to the Christian faith and her view of God has not changed, however her view of the Bible has been inextricably altered. John repeatedly quoted Scriptures when demanding that his wife submit to her husband. Jane believes that her Christian faith was of little help in dealing with her sexual assaults. Earlier in her life, Jane was almost molested by a pastor and she therefore never felt safe to approach any church leader regarding her problems. This remains her sentiment to this day.

Approximately two years ago, Jane sought the assistance of a social worker in private practice. She notes that the social worker gave her the skills to deal with her posttraumatic stress and to look towards the future.

Jane was adamant about changes that should be made in society and the church. Firstly, Jane suggests that more individuals need to be trained to assist those experiencing sexual trauma. Secondly, she finds that there should be more approachable and trained female church leaders who are understanding and empathic towards rape victims, since approaching a male church leader would be “unpleasant”. Jane still struggles with the ongoing after-effects of her trauma. Her perceptions of marriage and physical relationships are very negative and she notes that she battles to trust men at all. In fact, Jane feels threatened to be alone in the company of a male. Her self-esteem has been negatively affected by her rapes and does not find herself attractive. She struggles to feel appreciated and in control.

The outcome of Jane's *Impact of Event Scale – Revised* (Wiess & Marmar 1996) is found in Table 4.5, which indicates she suffers from high levels of intrusion because of the rapes.

IMPACT OF EVENT SCALE – REVISED

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to _____, which occurred on _____. How much were you distressed or bothered by these difficulties?

Item Response Anchors are:

0 = Not at all; 1 = A little bit; 2 = Moderately; 3 = Quite a bit; 4 = Extremely.

Thus, scores can range from 0 through 4.

1. Any reminder brought back feelings about it. **4**
2. I had trouble staying asleep. **2**
3. Other things kept making me think about it. **4**
4. I felt irritable and angry. **4**
5. I avoided letting myself get upset when I thought about it or was reminded of it. **4**
6. I thought about it when I didn't mean to. **0**
7. I felt as if it hadn't happened or wasn't real. **1**
8. I stayed away from reminders of it. **0**
9. Pictures about it popped into my mind. **4**
10. I was jumpy and easily startled. **0**
11. I tried not to think about it. **0**
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them. **1**
13. My feelings about it were kind of numb. **2**
14. I found myself acting or feeling like I was back at that time. **0**

15. I had trouble falling asleep. **1**
16. I had waves of strong feelings about it. **3**
17. I tried to remove it from my memory. **2**
18. I had trouble concentrating. **0**
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart. Cause me to punish myself. **0**
20. I had dreams about it. **3**
21. I felt watchful and on-guard. **0**
22. I tried not to talk about it. **0**
- Total IES-R score: **35**

The **Intrusion** subscale is the **MEAN** item response of items 1, 2, 3, 6, 9, 14, 16, 20. **20**

The **Avoidance** subscale is the **MEAN** item response of items 5, 7, 8, 11, 12, 13, 17, 22. **10**

The **Hyperarousal** subscale is the **MEAN** item response of items 4, 10, 15, 18, 19, 21. **5**

Table 4.5

4.4.4 Interpretation

The results from the *Impact of Event Scale – Revised* (Wiess & Marmar 1996) found in Tables 5.3; 5.4; 5.5; are now interpreted by making use of PTSD criteria as discussed in section 3.4.5.1 *Definition of Post Traumatic Stress Disorder*. Pastoral counsellors do not have the training to make a clinical diagnosis but it is useful to utilise the recognised tools of mental health practitioners in order make an assessment of how severely victims of spousal rape have been psychologically affected by their ordeal.

All three of the respondents were directly involved in incidents that were a threat to their physical integrity. Their feelings included fear and helplessness. This meets the first criterion for the diagnosis of PTSD. The second criterion is the presence of intrusion. Intrusion refers to nightmares, flashback memories and

invasive emotions responses that the victim experienced shortly after the rape/s. In order to be classified as PTSD at least one intrusive criterion should be identified. Cheryl noted that strong feelings of anger were evoked when thinking of the rapes. Mary has evasive thoughts and feelings concerning her rape. Jane has pervasive distressing thoughts, feelings and dreams regarding her trauma.

The third criterion for the diagnosis of PTSD is that of avoidance. Avoidance refers to the victims attempt to numb her experiences of the event. This could mean that they avoid the places, thought, persons and emotions. All three of the respondents express avoidance tendencies. Cheryl particularly avoids thoughts and places associated with her spousal rape incidents and expresses feelings of detachment, whereby she means that she feels like a mere observer of her life rather than actually participating in it. Mary also avoids thoughts and feelings which remind her of her spousal rape incidents. She too expressed a sense of numbness. Jane is less prone to avoiding thoughts and places that aroused recollections of her spousal rape incidents; however she avoids and represses strong emotions when confronted with recollections of the rapes.

The fourth criterion for the diagnosis of PTSD is that of arousal. Arousal refers to outbursts, exaggerated startle response, hypervigilance, and so on. Only one symptom of arousal is required for a diagnosis of PTSD. Cheryl meets one of the criteria, namely that of not being able to fall asleep. Mary meets three of the criteria: anger outbursts; as well as sleep difficulties. Jane meets one criterion that is, irritability and anger outbursts.

The fifth criterion for the diagnosis of PTSD requires that the symptoms of the disturbance are evident for more than one month. All three of the respondents have suffered their spousal rapes years ago and all three are still experiencing symptoms of disturbance and distress.

The sixth criterion for the diagnosis of PTSD requires that the incident has caused distress in areas such as social life, work, home and the like. All three of the respondents are currently in therapy as a direct result of the difficulties that they are experiencing in different areas of their lives. In addition to a possible diagnosis of PTSD that could be made by a qualified mental health practitioner, all three respondents suffer from depression for which they have been medically treated. It cannot be determined whether or not their depression is the direct result of their

spousal rapes; however it may be safe to assume that their rapes have definitely contributed to their depression.

Each of the respondents also endures additional psychological suffering of shame, guilt, low self-esteem and low self-confidence. These women have needed to reassess their worldviews (schemas) in the light of their experiences.

Relationships, especially those with men, have been affected. The ramifications of these difficulties and symptoms of PTSD may be even more difficult to deal with as these woman progresses through life. Herein lays an opportunity for the positive involvement of pastoral counsellors.

4.5. Summary

This chapter has analysed the data collected from two sets of questionnaires and three formal interviews. Making use of the DSM IV criteria for PTSD, this study shows that spousal rape victims often exhibit symptoms of PTSD, which in turn demonstrates the intensity of psychological injury that spousal rape victims suffer. The results also show that time does not necessary heal the wounds and that the victims continue to suffer years after the event, even if they are no longer in relationships with the perpetrators. Victims need some form of continued and adjunctive intervention in order to assist with recovery from their ordeals.

The data suggests that pastoral counsellors are quick to refer the victims of spousal rape to health care professionals. According to the current recognised modalities for treating posttraumatic stress, a number of mental health professionals who have participated in the survey are not adequately treating victims of spousal rape. This is either due to the specific methods they use, or to the limited time they spend with their clients.

The sixth chapter proposes an alternative pastoral counselling model by means of which to assist victims of spousal rape effectively. It also proposes some preventative measures.